701. C7.11. If receiving an enrollment form at any contractor port of entry counts for the purposes of calculating enrollment processing cycle time, will the Government allow the contractor to access DOES at any port of entry so the contractor can meet cycle time standards?

RESPONSE: No, centralized enrollment is required.

702. C7.15. In its response to question 30, the Government stated that current network enrollees would not be forced to change their enrollments if the MTF had capacity at the start of the new contract. In its reponse to Question 378, the Government stated that current network enrollees would require an exception from the MTF commander to remain enrolled with a civilian. Please clarify.

RESPONSE: In an upcoming amendment, Section C-7.15. will be changed to read, "If a beneficiary's civilian primary care manager remains in the TRICARE network, the beneficiary may retain their primary care manager. If the beneficiary must change primary care managers, all enrollments shall be to the MTF until MTF capacity, as determined by the MTF Commander, is reached."

703. C7.18. The RFP defines Health Care Finder services as the contractor providing "assistance in accessing information about other Department of Defense programs and applicable community/state/federal health care and related resources for all MHS eligible beneficiaries who require benefits and services beyond TRICARE." Conversely, the Policy Manual, Chapter 1, Section 8.1 states Health Care Finder services include referral assistance, continuity of care, and authorizations. Do both provisions accurately describe the Health Care Finder services?

RESPONSE: These provisions establish minimums. Defining the scope of duties of contractor employees, beyond what the Government specifies, is a contractor responsibility.

704. C7.2. Are MTF to MTF referrals part of the audit universe from which the contractor will draw its sample?

RESPONSE: No, the requirement is limited to referrals processed through the contractor.

705. C7.20.2. To allow offerors to plan for services they might offer, can the Government reveal whether it plans to offer HCIL triage services other than through the Managed Care Support contracts?

RESPONSE: The Government continues to evaluate the appropriateness of offering HICL services. For the purposes of this RFP, offerors should assume that HICL is not required.

706. C-7.21.15. Reference question 80: The answer to this question indicates that enrollment fee revenue by region is proprietary. Much more detailed information about healthcare delivery by prior contractor has been provided in the data tapes.

a. We respectfully request the government reconsider its answer to question 80.

b. What is the distinction about enrollment fees that makes them proprietary, compared to other released information?

c. What elements have local contractors introduced into the process to make them proprietary, given that the government sets all rules about amounts and payment patterns?

d. If the information is not available by prior region, could it be released in consolidated form by new region? If yes, please provide three years of history.

e. If the information is not available by new region, could it be released in consolidated form (for the past three years) on a national basis?

RESPONSE: The Government researched its response to question 80 (now numbered 82) regarding enrollment revenue and reconsidered. The response to question 82 has been revised to provide the requested data.

707. C7.21.17. Can the contractor deduct an administrative charge for billing agent/clearinghouse services from the provider's reimbursement?

RESPONSE: No.

708. C7.21.18. In its response to Question 67, the Government suggests that most cases of payments above CMAC will result from network adequacy. It is our understanding that, for TRICARE Prime Remote, networks are not required, and further, that providers who balance bill should be paid up to 115% of CMACs. In these situations, the payment above CMAC does not "result from network inadequacy," as a network is not required. In TPR situations, what is the justification for excluding such costs from underwritten health costs?

RESPONSE: TPR is excluded from the portion of this provision that prohibits the contractor from reporting amounts in excess of 100% of CMAC unless the TPR beneficiary resides in a TRICARE Prime service area.

709. C7.26. We recommend against providing a permanent presence for a Government representative at subcontractor locations as this could lead to claims between the contractor and subcontractor at which the Government would have to be called on to testify.

RESPONSE: Comment noted. However, we do not believe this will be the case as the Government individual(s) at the subcontractor is there to monitor and observe, not be involved in internal disputes between the Prime and the subcontractor.

710. C7.26. A risk exists that the Government representative will overstep the warrant and authority granted to the representative and demand action from the contractor (or subcontractor). What steps will the Government take to prevent this and enforce the condition that the Government representative may not direct the contractor?

RESPONSE: The Government will manage its staff appropriately.

711. C7.3.1. The first sentence suggests that the MTF has the right of first refusal for all referrals, both from civilian providers and MTF providers, within a Prime Service Area. The second sentence, however, defines the first right of refusal as applying only to referrals from civilian providers. It is clear that the RFP's technical

objectives and financial incentives encourage the contractor to send all referrals, regardless of source, to the MTF for exercise of right of first refusal, but it is unclear whether this is a requirement. Does the contractor have to forward all MTF referrals to an MTF it to exercise its right of first refusal?

RESPONSE: No, it is the MTF's responsibility to determine if capability and capacity exist within the Direct Care System prior to referring a beneficiary to the contractor.

712. C7.3.3. In the response to question 52, the Government states that the HEDIS standards for this solicitation would be the commercial set for managed care health plans. In the response to question 222, the Government states that the universe of all reporting plans means all plans as reported by NCQA. Please confirm that the applicable HEDIS standards are the commercial set for managed care health plans.

RESPONSE: Please see an upcoming amendment for which eliminates the HEDIS requirement.

713. C7.36.3. What will be the process and criteria for obtaining exceptions to the requirement that all network providers submit claims electronically?

RESPONSE: We believe you are referring to the provisions of Section C-7.1.10. The process is to submit a fully justified request to the Regional Director that demonstrates that allowing an individual providers to submit hard copy claims is in the best interest of the Government.

714. C7.36.3. Does the Government have information it can make available on rates of EMC filing for Medicare and barriers to achieving 100% EMC filing?

RESPONSE: Medicare EMC rates are available on Medicare's web page. We have nothing but anecdotal comments as to the barriers to electronic filing. We believe, however, that an offeror whose system is user friendly and who accommodates providers can fulfill the standard.

715. F5.a. Will the contractor be responsible for reviewing quarterly all new medical technology or just those items listed in the TRICARE Policy Manual, Chapter 1, Section 1.1, as the Government may modify it from time to time?

RESPONSE: The contractor is responsible for reviewing all new drugs, devices, medical treatments and medical procedures and bringing changes in the status of each to the Government's attention.

716. G3.b. G-3 b describes the contract payments disbursed by an MTF through the revised financing. The process described requires the contractor to disburse payments from its own account for all MTF prime and active duty supplement care delivered outside of the MTF. The amount for the services rendered would be invoiced at the end of the month and the MTF would have up to 30 days to provide payment, if, the MTF concurs with the invoice. The following questions apply to this process.

a. Given the size of the contracts, a contractor may experience $60-80 million in disbursements for MTF prime and active duty supplement in a given month. Does the Government intend the contractor to carry these payments as an accounts

receivable for at least 45 days (average payment made the 15th of the month and 30 days after month end for receipt of payment for service rendered).

RESPONSE: Yes

b. Does the Government intend to reimburse the contractor for the lost investment capital resulted from "floating" the Government $60-80 million a month?

RESPONSE: There is no provision for separate payment for a "float."

c. Does the Government have experience with administering this process previously?

RESPONSE: There is presently an MTF payment process in place in current Regions 1 and 2/5. The process for this solicitation is defined in the RFP.

d. If yes to "C" above, what is the average length of days outstanding for invoices provided to MTF?

RESPONSE: The current process has an average length of payment outstanding that ranges from 45 to 60 days.

717. G5. The offeror would like to be able to use issues of the past and future "STAT II REPORT" in predictive modeling as a part of proposal development. Please provide these reports.

RESPONSE: We have revised the RFP and the Stat II Report will not be used. Please see Amendment 4.

718. H1.b.(2)(a). During the annual renegotiation to set target healthcare costs, the contractor should take into account factors beyond its control. What data (including MTF data or eligibility data) will the Government supply to contractors to assist them in making this determination?

RESPONSE: The Government will provide the same MTF workload and population data files that have been provided in the RFP's historical data package, except the data will be limited to underwritten eligibles. For negotiating OP 2 targets, the Govt will provide the most recently available 36 months of data. For negotiating later option periods' targets, the Government will provide the most recently available 24 months of data.

719. H1.b.(2)(a). This paragraph defines the target health care cost to include "the purchased-care costs for non-TRICARE/Medicare dual-eligible CHAMPUS beneficiaries residing in the area, whether they are enrolled with an MTF PCM, a network PCM, or are non-enrolled." Attachment L-1, page 2, second paragraph under "Specific Information" states that the contractor is, "at-risk for the cost of all care and services provided to Prime enrollees (other than Active Duty members) having civilian PCMs, and for all TRICARE Extra and TRICARE Standard care." Please clarify which description (in Section H or Attachment L-1) is correct.

RESPONSE: The definition in H1.b.(2)(a) is correct and Attachment L-1, p. 2 will be corrected.

720. H1.b.(2)(b). During the annual renegotiation to set target healthcare costs, the contractor should take into account factors beyond its control What data (including MTF data or eligibility data) will be supplied to contractors to assist them in making this determination?

RESPONSE: Please see the response to Q 718.

721. H1.b.(2)(c). Will change orders be allowed for routine updates in CHAMPUS reimbursement levels?

RESPONSE: No.

722. H1.b.(2)(c). During the annual renegotiation to set target healthcare costs, the contractor should take into account factors beyond its control What data (including MTF data or eligibility data) will be supplied to contractors to assist them in making this determination?

RESPONSE: Please see the response to Q 718.

723. H12. Do offerors still need to provide a plan for assumption in whole or in part of another contract area?

RESPONSE: No plan is required as the requirement has been eliminated.

724. L10.h. Will the Government give an offeror access to the information the Government used to assess the offeror's past performance? Will the Government give an offeror access to this information relating to other offerors?

RESPONSE: The information used in the past performance evaluation will primarily be furnished by the offeror. If the Government develops additional negative information upon which the offeror has not had the opportunity to comment, the Government will provide such an opportunity. The Government will not release proposals (past performance information is a component of the proposal) to another bidder.

725. L11.e. The RFP stipulates that Microsoft Office 97 is to be used for proposal submission. Since HTML is compatible with the Internet Explorer application included with Office 97, can an offeror submit documents as part of its proposal that are in HTML format? This format can assist offerors in submitting proposals that are easier for the evaluators to navigate and understand.

RESPONSE: No, HTML does not fulfill the Government’s needs.

726. L13.d.(11). Will the Government's further clarifying questions relate only to areas questioned during the initial question period, or could the further clarifying questions apply to any part of the offeror's presentation?

RESPONSE: The Government reserves the right to ask clarifying questions about any component of the offeror’s proposal.

727. L13.f.(2)(d). Are Past Performance Reports required only from First Tier sub-contractors included in the partnering team proposed for MDA906-02-R-0006 and

not for sub-contractors included in a partnering team associated with past or current contracts? Please confirm.

RESPONSE: You are correct. However, if a report is issued concerning the Prime's performance under a current or past contract, and it also includes the performance of a subcontractor, a copy of the report is required. For example, a government performance report is issued to the Prime contractor concerning the claims processing activities under that contract, but the majority of the claims processing occurs as a subcontractor activity, the Prime is still responsible for that subcontractor's activity and that report would be submitted since it would contractually be on the Prime.

728. L13.f.(2)(i). We assume that Final Reports and/or Findings issued to First Tier sub-contractors included in the partnering team proposed for MDA906-02-R-0006 must be submitted and not Final Reports and/or Findings issued to sub-contractors included in a partnering team associated with past or current contracts. Please confirm.

RESPONSE: You are correct. See also the answer to question 727.

729. L13.f.(4)(o)(2). Will the Contractor be reimbursed on a monthly pro-rata basis of the $2 million disease management/case management CLIN, or will the reimbursement be based on a proposed fixed fee (if contractor is allowed to propose an amount greater than $2 million)?

RESPONSE: Disease management/case management is a cost-reimbursable line item. The contractor may invoice monthly for actual administrative costs incurred for disease management/case management programs approved by the Regional Administrative Contracting Officer.

730. L13.f.(4)(o)(2). Does contract cost include Healthcare and Administrative cost when calculating the 10% of contract cost for the disease management/case management CLIN?

RESPONSE: The ten percent fee applies to the administrative costs associated with the disease management/case management activities. There are no health care costs on this CLIN.

731. L13.f.(4)(o)(2). Please clarify how this CLIN is described as cost reimbursable in the second sentence of L-12 f.4.2. and then describes the fee to remain a fixed amount regardless of level of expenditures. Cost reimbursable CLIN and Fixed Fee appear to be in conflict with one another.

RESPONSE: There is no conflict in this contract structure. FAR Part 16.3 allows for a cost-plus-fixed-fee contract type. The disease management / case management CLINs are structured in this manner and are allowable in accordance with the FAR.

732. L13.f.(4)(o)(2). Please clarify how the Government will determine whether a contractor has exceeded 10% of the estimated contract cost for this CLIN.

RESPONSE: Offerors are required to propose both a fixed fee amount and a fee percentage in each of the option periods. The Government expects there to be consistency between the proposed fee percentage and the underwriting fee amount.

733. L13.f.(4)(o)(2). Can a contractor propose an amount greater than the $2 million level of effort estimate for case management/disease management services?

RESPONSE: No. Please refer to the answer for Question 388.

734. L-1 Page 3. Please describe the activities and functions of the Government's TRICARE Call Center. What responsibilities will this entity have as opposed to the contractor?

RESPONSE: The Government's call center will route calls to the contractor. The contractor shall not rely on the Government to answer any calls at our call center or any other location. Further, the contractor shall not rely on the Government to provide any support in responding to walk-in inquiries at TSCs. In all cases, the contractor is responsible for responding to 100% of inquiries without Government assistance.

735. L-3 2. What are the applicable components of the Beneficiary Survey? Is the referenced Beneficiary Survey the one question beneficiary-user satisfaction telephone survey in Attachment L-3 or is it the Health Care Survey of DOD Beneficiaries?

RESPONSE: The applicable components are those that the Regional Director determines accurately reflects the contractor's performance. The beneficiary satisfaction survey reference is the survey contained in attachment L-3. Please remember that the Regional Director may elect to use any and all information available for any source in making the award fee determination.

736. L-3 5.3.1. Will the HPA&E-tabulated survey be the current survey, or will the Government revise it to enhance the methodology used for gathering customer feedback?

RESPONSE: The survey referenced is the survey contained in the attachment. The Government reserves the right to unilaterally modify the instrument and methodology at any time.

a. Might the Managed Care Support contractors, through the Integrated Process Team process or other forums, have an opportunity to participate in any revisions?

RESPONSE: We strive to partner with our contractors to achieve the optimum results in every area.

737. L-9 L-9. Do the TRICARE for Life workload data include work that the TRICARE Dual Eligible Fiscal Intermediary Contractor will perform? If so, how much of this workload will the TFDEFIC perform?

RESPONSE: The MCSC is responsible for all walk-ins to TSCs for all classes of MHS beneficiaries. The MCSC is also responsible for answering every question received via any media from any MHS beneficiary that can be answered without access to another contractor's data. For example, if a beneficiary asks about TFL benefits, the MCSC shall answer the question, if a beneficiary asks how to read an EOB, the MCSC will answer the question, if a TFL beneficiary asks how a claim was paid and presents the EOB, the MCSC shall answer the question, if a TFL beneficiary asks for a referral

to a network provider the MCSC accomplishes the referral. However, if the beneficiary asks for the status of a claim, the MCSC shall refer the beneficiary to the TDEFIC contractor as only the TDEFIC contractor has this knowledge. The Government has not way of determining which telephone calls contained in the data presented in Attachment L-9 refer to information only the TDEFIC contractor could provide. 100% of walk-ins are the responsibility of the MCSC.

738. M3.a.(1). How can the Government meet the FAR 15.002(b) definition of a competitive acquisition and the price analysis guidelines of FAR 15.404-1(b) if the Government excludes post-OP1 health care costs from price evaluation?

RESPONSE: A deviation to the FAR on this issue was requested and received. Please see our response to question 490 that spells out the issues and the reasons for the approach in detail.

739. M6.b. What levels of services are subject to possible increase of performance standards, "as necessary, to achieve the required level of service"?

RESPONSE *Revised 30 December 2002*

RESPONSE: See L.12.m., which was added by Amendment 0004.

740. M6.b. How will the Government evaluate the offeror's ability to answer questions from the audience? Please identify the audience to which the Government refers in this paragraph.

RESPONSE: The Government will evaluate the offeror’s proposal for achieving the requirement. It is the offeror’s responsibility to demonstrate that it can fulfill the requirement to conduct thousands of briefings to all variety of audiences with competent staff. For example, the contractor’s briefing model could include the contractor’s own questions to the audience and then with a proposed response asking the audience if the statement is correct. However, the techniques of presentation are left to each offeror to propose.

741. M6.b. Please explain how the Government will evaluate the offeror's ability to prsesent material, "in a manner interesting to varied audiences". What audiences fall into the category of "varied"?

RESPONSE: Please refer to our response to question 740.

742. M8.b.(1). The last sentence of this paragraph states the Government will adjust costs, for "those aspects of the buildup determined to be unrealistic". This negative test implies that there is a range of portential results that could be considered unrealistic, and that no results within this range would be adjusted. Is this conclusion correct?

RESPONSE *Revised 30 December 2002*

RESPONSE: The cost evaluation section of the RFP has been significantly amended since this question was submitted. Offerors should refer to the answers provided to Questions 525, 525.a, 525.b. and 525.c. for relevant information regarding the cost realism methodology that will be used by the Government.

743. M8.b.(1). This paragraph indicates that proposed target costs for underwritten health care would be reviewed for cost realism, but reasonableness is not a review element. Is this correct?

RESPONSE: The assumption is correct. Price reasonableness determinations are performed on priced line items for known requirements. Health care is not a known requirement and is, therefore, procured through this solicitation as cost-reimbursable line item. Thus, a probable cost determination using cost realism analysis is used for evaluation and award purposes.

744. The TRICARE System Manual refers to the government catastrophic cap and tracking system by numerous titles. It is difficult to determine what may be a 'repository system' versus the name of the data stored there. In Chapter 3, CC&D is used for Catastrophic Cap and Deductible Data and DEERS Claims Catastrophic Cap and Deductible. In Chapter 4, text still refers to Central Deductible and Catastrophic Cap File (CDCF). Chapter 8 of the TRICARE Operations Manual refers to DEERS Deductible and Catastrophic Cap Data (DDCD). The CDCF Data Dictionary discussed in the TRICARE Systems Manual Chapter 4, Addendum A, still refers to the old DEERS fields. What will the MCSC be required to access for deductible and catastrophic cap patient and family information? Is it CHCS, CC&D, or DDCD? If these are different systems, will a data dictionary be provided for the new systems?

RESPONSE: Please re-review your references. We are unable to determine what chapters and manuals you are referring; e.g., the TSM Chapter 4 concerns referrals and authorizations and makes no reference to the CDCF.

745. The RFP lists 7 different transition periods for the three contracts being awarded. Please reference Chapter 1, Section 8, Item 3.0 – Instructions for Benchmark Testing, in the TRICARE Operations Manual. The requirement is that benchmark will be prior to the start of healthcare delivery but is not specific as to whether that is per region or per transition period. Will there be a benchmark before each start date or before the first state date for each new region?

RESPONSE: The Government reserves the right to conduct a benchmark test as each existing region is transitioned.

746. Please reference Chapter 1, Section 8, Item 1.2, Transition Specifications Meeting in the TRICARE Operations Manual. Will the three contract awards be announced simultaneously? If so, will the three meetings in Aurora be held concurrently, or will they be held separately at different dates?

RESPONSE: The three meetings will be held separately, although they may occur on the same date.

747. TRICARE Operations Manual Chapter 3, Section 9.1 states that the contractor shall be paid for payment record claims at the claim count methodology and rates set forth in the contract, upon acceptance or provisional acceptance (as defined by the TRICARE Systems Manual) of the payment records by the TED record edit systems. It further states, "If claims are adjusted and no longer quality for a claim rate, or are discovered to be invalid, or the claim rate is contractually changed (definitized) later, these payments will be adjusted accordingly." Please explain in what circumstances a claim no longer qualifies for a claim rate. If the contractor will

not receive the claim rate for all payment records accepted or provisionally accepted by TEDS, please define which type of submissions do not qualify for the claim rate.

RESPONSE: An adjustment to a claim that should not have been submitted as a separate claim might be an example of such circumstances. At present there are not types of submissions which do not qualify for claim rate but the provision is included to accommodate any possible future program needs. If such program needs were to arise, appropriate contractual adjustments would be made.

748. Section H-5.d in the RFP states that the results of the Allowable Health Care Audit will be applied to the entire universe from which the audit sample was drawn to determine total unallowable costs. It is fully expected and understandably prudent for the DoD to protect government funds through a method that limits the government's financial exposure as a result of contractor overpayments. However, this provision as currently stated in the RFP results in a zero tolerance for overpayment errors. Is it unreasonable to expect that a contractor can achieve 100% accuracy in claims processing for a health care program issuing billions in health care payments annually? As currently stated, this requirement will significantly increase administrative costs for contractors who will be compelled to develop an infrastructure that attempts to achieve this unattainable goal. We believe that a more reasonable approach to this objective that not only protects the government from overpayment of health care dollars but also is administratively feasible for the contractor is to establish an acceptable tolerance for errors and then to assess the penalties for overpayments above this predetermined threshold. This recommendation is comparable to the performance guarantee for payment errors currently in the RFP, whereby the government will withhold 10% of the value of payment errors exceeding 2%. A similar tolerance for the allowable health care audit will ensure the government retains the necessary controls for stewardship of government funds while maintaining cost-effective administrative requirements.

RESPONSE: Please refer to our response to question 85 and 551.

749. Reference the RFP Section C-7.23. Is the incoming contractor required to adjust claims from the prior contract using a converted TED record, in HCSR format, or will the claims be marked as not having a prior HCSR/TED record available to adjust?

RESPONSE: The incoming contractor is required to adjust claims processed by the prior contractor. These non-TED records are to be submitted in TED format using the original HCSR ICN and the Adjustment Key field which indicates the HCSR suffix on the original submission.

750. Section C-5 refers to Government Furnished Property and Services and states that "Government property furnished to the contractor for the performance of this contract includes the furnishing of telephone lines and computer drops in accordance with General Services Administration (GSA) direction". Please advise specifically what property and services will be provided in accordance with the statement as Government Furnished Property and Services. For example, will this include the property and services to fulfill the RFP requirement of section C-7.20.2 that states, "The contractor shall establish twenty-four hour, seven days a week, nationally accessible (to include Hawaii and Alaska) telephone service"?

RESPONSE: The referenced Government furnished property is limited to TSC space and the equipment listed in Section J, Attachment 8 data package.

751. C-7.1.16. states "The contractor shall ensure that network specialty provider clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the beneficiary's primary care manager within five working days..." We assume that the contractor is only responsible for this requirement for specialty care including mental health that the PCM has specifically referred out and not where beneficiaries self refer such as the "free" eight mental health visits. Please confirm.

RESPONSE: You are correct; however, our expectation is that mental health providers exercise proper professional judgement and share the information with the PCM when clinically indicated.

752. Section C-7.21 of the RFP states the claims processing system shall be a single data base and be HIPAA compliant. The government response to question #102 stated the requirement is for a single system. Please clarify as to whether the claims processing system for the South region has to accommodate both CONUS and OCONUS claims. Can a separate processor be used to adjudicate foreign claims in accordance with section C-7.21.14?

RESPONSE: It is acceptable to propose a separate system for foreign claims.

753. The TRICARE Operations Manual updated August 26, 2002, Chapter 6, Section 1, 7.2, Enrollment Expiration, states: "The contractor shall disenroll the beneficiary effective retroactive to the enrollment expiration date and shall send written notification to the beneficiary and the reason for the disenrollment." However, the next sentence states: "DMDC sends this written notification within five business days of the disenrollment transaction." Please confirm whether the Government intends for the contractor or DMDC to send out the notification to the beneficiary.

RESPONSE: In an upcoming amendment we will clarify that DMDC will send the notice.

754. Data tape file "Q5_PartA-3Jul02.xls," contains information regarding the physical attributes of the current TRICARE Service Centers that are either in the MTF or on the military installation, gives square footage for the listed TSCs. Can a potential offeror assume that the Government intends to allow the selected offeror to use this square footage in the MTF or on the military installation?

RESPONSE: Yes

755. The data tapes do not provide information on TRICARE Service Centers (TSCs) in BRAC sites. Can an offeror assume that the only locations where TSCs are required are those locations shown on the data tape file "Q5_PartA-3Jul02.xls," which contains information regarding the current TRICARE Service Centers, and which are located either in the MTF or on the military installation? If this assumption is not correct, please provide a list of sites not associated with MTFs where TSCs are required. Also, please provide workload currently performed at any required TSC site

not shown on data tape Q5_PartA-3Jul02.xls since data tape file Q5_PartB_3Jul02.xls only shows workload for TSCs in an MTF or on a military installation.

RESPONSE: TSCs are required at all MTFs and BRAC sites. At BRAC sites the TSCs are in contractor furnished space. You have been provided with all Government data concerning TSC workload.

756. On the data tapes, other than Active Duty eligibles who are enrolled to the network, PCMs are identified in a single 69 series DMIS for Regions 3 through 12. There are 266,538 in the new South Region (DMIS: 6903, 6904, 6906) and 171,318 in the new West Region (DMIS: 6907, 6908, 6909, 6910, 6911, 6912). In order to accurately project staffing requirements and estimate health care cost, we would need to know how these network-enrolled beneficiaries are broken down by Prime Service Area. When will the Government provide this level of data?

RESPONSE: The contractor can extract this level of detail from the payment record data tapes included in the data package.

757. RFP L.13.f(2)(g) requires that the offeror provide contact information as specified in Attachment L-5 on terminated and/or not renewed accounts, to be completed by the "most cognizant officer of the account." If the terminated account declines to complete the form and sign L-5, may the bidder attest to the contract information?

RESPONSE: Yes; however, the bidder must provide the name and contact information on the account in sufficient detail to allow the Government, should it desire, to contact a cognizant official of the account. Failure to provide this information may result in an adverse action by the Government.

758. CLIN 0104AA - This CLIN requires a PMPM price for a quantity of 15,415,560 member months for the first six-month period of Option Period I. Due to the staggered transition of health care delivery in the respective geographic areas, the first six months will have significantly less member months than 15,415,560. The 15+ million member month quantity will not be reached until the seventh through twelfth month of OP I (CLIN 0104AB). Section L.13.f (4)(j), Page 89 states: "the Government has established an estimated number of MHS eligible beneficiaries for each option period for evaluation purposes as provided in Attachment L-8." Section G-4 and G-5 indicate that the PCO will issue a delivery order for each six-month period for the PMPM CLIN (0104AA).

a. For the initial six-month period of OP I, is the Government's intent to issue a delivery order for less than the full 15,415,560 member months due to the staggered transition of geographic areas?

RESPONSE: Yes; however, the offeror is asked to monitor upcoming amendments for revisions to this number based on the phase-in of the outgoing regions.

b. Is it correct to assume that the delivery order will be the basis for payment of CLIN 0104AA? If yes, is the Government's intent in the RFP to solicit a PMPM price for evaluation based on a larger quantity of member months than it intends to order for CLIN 0104AA?

RESPONSE: Yes the delivery order will specify the number of individuals for which a PMPM may be charges and no, the Government's intent is not to base the evaluation on an inaccurate number.

c. Are offerors expected to submit a unit price for CLIN 0104AA based on the estimated costs necessary to provide service for 15,415,560 member months or to submit a unit price based on the estimated costs for the number of member months the Government intends to order?

RESPONSE: On the number of member months the Government intends to order which will be reflected in an upcoming amendment.

d. Would the Government consider amending the member month of CLIN 0104AA to correspond to the applicable member months for the staggered transition of geographic areas? This same question set applies to CLINS 0607AA and 1106AA.

RESPONSE: Yes, this is occurring.

759. C-7.1.16 states that "the contractor shall ensure that network specialty providers provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the beneficiary's primary care manager within five working days of the specialty encounter 98% of the time. In urgent/emergent situations, a preliminary report shall be conveyed to the beneficiary's primary care manager within one hour by telephone, fax or other means with a formal written report provided within the standard. All consultation or referral reports, operative reports and discharge summaries shall be provided within the standard. All consultation or referral reports, operative reports and discharge summaries shall be provided to the primary care manager within 30 calendar days."

a. To measure the various timeliness standards relative to the day (or hour) of the specialty service in the above requirement, the time of the service (i.e., the starting point) must be known. How can the time of service be systematically known without imposing the requirement of appointment setting for referrals on the T-Nex program contractor? Or, does the Government intend that the contractor make appointments for referrals in the administration of the T-Nex program? Requiring a performance standard that presupposes a known appointment time is tantamount to imposing the appointing requirement itself.

RESPONSE: We disagree. While the standards are being revised in an upcoming amendment, contractor monitoring of their network does not necessarily include appointing. When responding to the RFP, offerors should propose their best practices for achieving the required outcome.

b. What constitutes an "urgent/emergent situation" in the context of the one hour reporting requirement mentioned above?

RESPONSE: Please refer to the definitions contained in the TRICARE Policy Manual and TRICARE Operations Manual.

c. In the ambulatory care setting in the private sector, it is generally accepted that a referring physician who is concerned enough about the "urgent/emergent situation" of their patient would telephone the needed specialist to convey the specific clinical issues. They would reasonably expect a telephone call back from the specialist with

the treatment recommendations. If the urgent/emergent situation is intended to focus on the ambulatory care setting and the Government elects to impose this standard, it may be appropriate to require a PCM who expects a telephone call within one hour from a specialist to also make the initiating call to the specialist to assure that he has all the appropriate information to assist in the care of the patient. If the clinical situation did not require a telephone call from the PCM to the specialist, it would be inappropriate to impose that requirement on the specialist. Nonetheless, the same issues arise regarding the ability to capture the initiation of the telephone call to which the PCM would be held accountable. In the emergency room, a trauma surgeon in an "urgent/emergent situation" called to consult on a patient (whose payor source, primary care manager and health benefit program requirements may be unknown) would not be expected to make a telephone call within one hour. Since emergency services do not require prospective approval, what programmatic mechanism does the Government understand would be used to identify the urgent/emergent event for their auditing purposes?

RESPONSE: The key is the referral. Since no referral exists in many emergent situations, the requirement does not apply.

d. Telephone contacts between providers are not reimbursable under the TRICARE rules. There is substantial accepted variation in the way that these interchanges (e.g., phone calls) are acknowledged by clinicians. How does the Government expect to audit the timeliness of telephone calls?

RESPONSE: The Government expects the contractor to propose their best practice in accomplishing these audits.

760. C-7.21.3, Page 29 states claim forms (UB-92, HCFA 1500s, and their successors) shall be accepted for processing. Please clarify the meaning of successors and any limiting factors. The addition or expansion of data fields within a claim form could result in significant modifications being needed for the claims processing system.

RESPONSE: We understand your concern; however, these nationally utilized forms will change over time and the contractor must accommodate those changes in their TRICARE business just as they will have to accommodate the same changes in their commercial business. In preparing their proposal, offerors must include any costs they project in relation to these changes.

761. C-2.1 Objective 5, Page 23 - Ready access to contractor maintained data to support the Department of Defense's (DoD) financial planning, health systems planning, medical resource management, clinical management, clinical research, and contract administration activities.

a. With respect to data definition, please provide a DoD's definition of:

- financial planning
- health systems planning
- medical resource management

- clinical management
- clinical research, and
- contract administration activities

RESPONSE: As these terms are readily and routinely used within the industry, we do not believe that special Government definitions are required.

b. There are a number of references to "Electronic/Electronically" (C-7. 1.8, C-7.1.10, C-7-1-15, C-7.5, C-7.6, C-7.11, C-7.14, C-7.21, C-7.21.2, C-7.21.3, C-7.21.4, C-7.21.10, C-7.22, C-7.23, C-7.23.1, C-7.25, C-7.26, C-7.36.1, C-7.36.2, C-7.36.3, C-7.37, C-7.37.1) with respect to submission of and access to data/information. Also, throughout the RFP there are a number of associated media statements; fax, written paper, paper forms, lists, reports, e-mail, telephone, world wide web, verbal, video teleconferencing, et cetera. What is the Governments definition of Electronic/Electronically?

RESPONSE: Again, industry standards apply. For instance, no one in the industry considers a faxed claim electronically submitted. However, for the purposes of this RFP, the offeror should define their meaning and the Government will determine if the contractor is fulfilling these readily understandable requirements.

762. C-5, Page 23 - Government-Furnished Property and Services. Government property furnished to the contractor for the performance of this contract includes the furnishing of telephone lines and computer drops in accordance with General Services Administration (GSA) direction. At certain MTFs, space and equipment may be provided for the TRICARE Service Center (TSC). This may include information management hardware and software to allow the contractor to access the Composite Health Care System (CHCS). Equipment at the TRICARE Service Centers is described in Section J, Attachment 8, List of Data Package Contents.

a. Will the telephone lines provide direct access (POTS) or will the circuit be routed through a government switch/PBX?

RESPONSE: These lines vary by location.

b. Will the computer drops be connected to the MTF LAN?

RESPONSE: This will vary by location.

c. Will drops provide connectivity outside the MTF (Internet)?

RESPONSE: This will vary by location.

d. Will the information management hardware/software allow the Associate to perform non-CHCS related functions (word processing, internet)?

RESPONSE: The offeror may not assume even CHCS connectivity.

e. What level of access to CHCS data, beyond "read-only" will be provided?

RESPONSE: We will not guarantee CHCS connectivity.

f. What are the CHCS access rules, data management allowances and method?

RESPONSE: Please see our previous response.

763. C-7.1.8, Page 25 - The contractor shall maintain an accurate, up-to-date list of network providers including their specialty, gender, work address, work fax number, and work telephone number for each service area, whether or not they are accepting new beneficiaries, and the provider's status as a member of the Reserve Component or National Guard. The contractor shall provide easy access to this list for all beneficiaries, providers, and Government representatives.
For the purposes of this requirement, "up-to-date" means an electronic, paper, telephone or combination of these approaches that accurately reflects the name, specialty, gender, work address, and work telephone number of each network provider and whether or not the provider is accepting new patients. The information contained on all electronic lists shall be current within the last 30 calendar days. "The information contained on all electronic lists shall be current within the last 30 calendar days."

Is the data currency required on a "rolling" 30-day basis or an end-of-month basis?

RESPONSE: Rolling 30-day basis.

764. C-7.10, Page 27 - All enrollments, re-enrollments, disenrollments, and transfers, to include enrollment activities of TRICARE Plus, shall be in accordance with the provisions of the TRICARE Operations Manual, Chapter 6 and the TRICARE Systems Manual. The contractor shall accomplish primary care manager by name assignment in Composite Health Care Systems (CHCS) for all MTF prime enrollees, including written notification to the beneficiary providing the name, location, and telephone number of the PCM.

a. In general, what level of access to CHCS data, beyond "read-only, will be provided?

RESPONSE: The reference to CHCS was deleted in Amendment 0001. We will not guarantee any access to CHCS.

b. What are the CHCS access rules, data management allowances and method? (also referred to in C-5)

RESPONSE: The C-7.10 reference to CHCS was deleted in Amendment 0001. The C-5 reference is only an example of GFI that may be provided. We will not guarantee any access to CHCS.

765. C-7.11, Page 27 - The contractor shall use the TRICARE Enrollment and Disenrollment Forms that are located at Section J, Attachments 2 and 3. The contractor shall reproduce the form as necessary to ensure ready availability to all potential enrollees. The contractor shall implement enrollment processes that take advantage of current technology while ensuring access and assistance to all

beneficiaries which does not duplicate Government systems. What is the government's specific definition of "current technology"?

RESPONSE: Current means contemporary. For example, XYZ technology may be state of the art in 2002; however, in 2005 ABC may be the current technology. The requirement is to keep pace with technology.

766. C-7.21.2, Page 28 - The contractor shall provide data at the beneficiary, non-institutional and institutional level, with the intent of providing the Government with access to the contractor's full set of data associated with TRICARE. The data shall include, but is not limited to, data concerning the provider network, enrollment information, referrals, authorizations, claims processing, program administration, beneficiary satisfaction and services, and incurred cost data.

a. This requirement states "providing the Government with access to the contractor's full set of data associated with TRICARE." The requirement also references "but is not limited to." What additional data does this requirement refer to?

RESPONSE: This is an opportunity for the offeror to propose the data elements it will make available to the Government and distinguish itself from other offerors.

b. The term "but not limited to" is far too vague and needs removal, further definition by the Government, or specific clarification through a MOU.

RESPONSE: Please see our previous response.

767. C-7.21.4, Page 29 – The contractor shall, as one means of electronic claims submission, establish and operate a system for two-way, real time interactive Internet Based Claims Processing (IBCP) by providing web based connectivity to the claims/encounter processing system for both institutional and non-institutional claims processing. - This IBCP system shall provide immediate eligibility verification by connectivity to DEERS and provide current deductible, Catastrophic Cap, and cost share/co-payment information to the provider on-line by connectivity to the DEERS catastrophic loss protection function and connectivity to the authorization system. - The IBCP system shall comply with Department of Defense Information Technology Security Certification and Accreditation process (DITSCAP) and encryption requirements. The contractor shall regularly update the IBCP system to utilize newer encryption security protocols.

a. Is the use of the term "two-way" redundant as the term "interactive" is used later in the sentence? If not, what is the definition of the term "two-way" ?

RESPONSE: Section C-7.21.4, is being revised. The redundant language has been removed. The section is being revised to read,"

C-7.21.4. The contractor shall, as one means of supporting electronic claims submission, establish and operate an interactive Internet-Based Claims Processing (IBCP) system for institutional and non-institutional claims. The IBCP system shall provide eligibility verification and provide current deductible, catastrophic cap and cost-share / co-payment information to providers authorized to use the system. The

contractor shall obtain the necessary information from DEERS through the Health Care Coverage Inquiry for Claims and incorporate the information into the IBCP system for access by system users. The IBCP system shall not have a direct interface to DEERS. The contractor shall ensure that the IBCP system complies with HIPAA Transaction and Code Set and Privacy requirements to include protecting the data from unauthorized access.

b. What are the "encryption requirements" and where are they defined?

RESPONSE: Section C-7.21.4, has been revised and the reference to encryption has been removed. The requirement is for the contractor to protect the data from unauthorized access. It is expected that the contractor will propose and use best commercial practices in protecting the IBCP data from unauthorized access.

768. C-7.27, Page 31 - The prime contractor and each first tier subcontractor shall provide full-time office space and support services to the Government representative equivalent to and in the proximity of the senior management of the contractor or first tier subcontractor. This shall include a fully-functional office including a private, lockable office; all appropriate office furnishings and supplies comparable to the senior managers of the contractor/subcontractor; a personal computer with email and World Wide Web access; printer; telephone instrument with unlimited capability; and photocopy or access to photocopy equipment.

Does the requirement for " … telephone instrument with unlimited capability…. " require international access?

RESPONSE: Yes.

769. C-7.26, Page 32 – Personnel Security. The Government shall coordinate with the contractor to initiate and document all activities necessary to ensure compliance with the Personnel Security Program. All contractor employees with access to Government systems must be designated ADP level I, II, or III and complete the appropriate background check as described in Appendix K to DoD 5200.2-R (Section J, Attachment 5).

Will the Government assure that the personnel accessing the contractors data are designated at ADP level I, II, or III and have completed the appropriate background check as described in Appendix K to DoD 5200.2-R (Section J, Attachment 5)?

RESPONSE: Please refer to the TRICARE Systems Manual, Chapter 1, Section 1.1, Subsection 3.3.4.1. and Chapter 1, Addendum A for requirements regarding ADP/IT Position Categories. The requirements apply to all personnel who access DoD Sensitive But Unclassified (SBU) information, DoD AISs/networks or contractor AISs/networks with DoD interconnections. All DoD civilian and military employees are required to complete the ADP process prior to entry on duty.

770. C-7.36.1, Page 32 - System Security. The contractor shall acquire, develop and maintain the DoD Information Technology Security Certification and Accreditation Process (DITSCAP) documentation to ensure both initial and continued DITSCAP Certification and Accreditation (C&A) for all contractor systems/networks processing or accessing Government sensitive but unclassified (SBU) data. In addition, the contractor shall modify the DITSCAP documentation as needed to address how identified security risks were addressed and mitigated. The contractor shall

cooperate with and assist the Government's (MHS) DITSCAP C&A Team during all phases of the C&A process by providing documentation in accordance with the MHS DITSCAP C&A team schedule. The contractor shall also put in place processes that provide and ensure at least a TCSEC C2 level of security protection for any Government-owned contractor-operated (GOCO) and/or contractor-owned contractor-operated (COCO) systems/networks that process MHS SBU information. These requirements are further defined in DoD 5200.40 (DITSCAP) and Section J, Attachments 4, 5, and 6.

a. Should the MCSC expect that there will be additional security requirements at the base and MTF level, differing by Service and individual locations?

RESPONSE: Yes. Please refer to the TRICARE Systems Manual, Chapter 1, Section 1.1, Subsection 4.5.

b. Will there be more than one Designated Approval Authority (DAA) for each contract?

RESPONSE: There will be one MHS DAA, but if contractors have to negotiate at a local level (Base/Post/Camp), the local DAA will also be involved.

c. What sort of agreements will be required between the MCSC and the government to provide "ready access to contractor maintained data to support DoD's financial planning, health systems planning, medical resource management, clinical management, clinical research, and contract administration activities" and still remain DITCAP compliant?

RESPONSE: Please refer to the TRICARE Systems Manual, Chapter 1, Section 1.1, Subsections 3.3.1 through 3.3.6 for DITSCAP requirements. All contractor systems interconnected with a government system must be and remain DITSCAP certified. Bidder proposals should describe how they intend to make the information available to the government.

d. What level or type of authentication will be required to "provide ready access to contractor maintained data to support DoD's financial planning, health systems planning, medical resource management, clinical management, clinical research, and contract administration activities?"

RESPONSE: It is not clear what is meant by "level or type" of authentication. If the question refers to the security requirements for transmitting this data, then the applicable requirements are provided in the TRICARE Systems Manual, Chapter 1, Section 1.1., beginning in Subsection 2.2. If the question refers to the accuracy of the data itself, all data required to meet this objective will be subject to audit through normal contract audit processes.

e. Will the MCSC be responsible for documentation and C&A of any GOCO systems/networks processing MHS SBU located at a MTF?

RESPONSE: Please refer to the TRICARE Systems Manual, Chapter 1, Section 1.1. for clarification of the certification and approval process. The MHS Information

Assurance Team is responsible for certification and approval of contractor operated systems that interconnect with government systems. Beginning at Chapter 1, Section 1.1, Subsection 2.2 of the TRICARE Systems Manual contractor responsibilities for the certification and approval process is described

f. Post DITSCAP C&A, what time period (annually/three years) is estimated for re-accreditation, assuming no MCSC system changes?

RESPONSE: Please refer to DoDI 5200.40 for detailed information on the DITSCAP process. As noted in the TRICARE Systems Manual, Chapter 1, Section 1.1, Subsection 2.3, OMB Circular A-130 requires certification and approval every three years or sooner if changes occur that require re-accreditation. Please refer to Subsection 3.3.3. for the URL where the above referenced documents can be obtained.

771. C-7.36.2, Page 32 - The contractor shall comply with DoD Minimum Security Requirements (DoD Directive 5200.28), C2 Requirements (DoD Directive 5200.28-STD), Privacy Act Program Requirements (DoD 5400.11), Personnel Security Program (5200.2-R) and the MHS AIS Security Policy Manual. The contractor shall also comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, specifically the administrative simplification provisions of the law and the associated rules and regulations published by the Secretary, Health and Human Services (HHS) and the published TMA implementation directions. This includes the Standards for Electronic Transactions and the Standards for Privacy of Individually Identifiable Health Information. It is expected that the contractor shall comply with all HIPAA-related rules and regulations as they are published and as TMA requirements are defined (including security standards, identifiers for providers, employers, health plans, and individuals, and standards for claims attachment transactions).

The requirement addresses "TMA implementation directions." Are the directions referenced found in other than the TOM or TSM?

RESPONSE: Implementing directions are found in both manuals.

772. C-7.36.3, Page 32 - The contractor shall ensure that all electronic transactions, for which a standard has been named, comply with HIPAA rules and regulations and TMA requirements. The Standards for Electronic Transactions apply to all health plans, all health care clearinghouses, and all health care providers that electronically transmit any of the electronic transactions for which a standard has been adopted by the Secretary, HHS. Electronic transmission includes transmission using all media, even when the transmission is physically moved from one location to another using magnetic tape, disk or CD media. Transmission over the Internet, Extranet, leased lines, dial-up lines and private networks are all included. Transmissions of covered data content via telephone conversations, fax machines, and voice response systems are not covered by the Standards for Electronic Transactions, however privacy and security requirements apply to these transmissions. Health plans and other covered entities conducting transactions through business associates must assure that the business associates comply with all HIPAA requirements that apply to the health plans or covered entities themselves.

The requirement states, "The contractor shall ensure that all electronic transactions, for which a standard has been named, comply with HIPAA rules and regulations and TMA requirements. " and "Electronic transmission includes transmission using all media, even when the transmission is physically moved from one location to another using magnetic tape, disk or CD media." Please clarify electronic transmission of physically moved media.

RESPONSE: Please refer to the HIPAA implementing law, regulations and the TOM, Chapter 21 for the definition.

773. C-7.37, Page 32 - The contractor shall furnish the DoD TRICARE Operations Center and all Health Benefits Advisors and Beneficiary Counseling and Assistance Coordinators located in each region with read only access to claims data. The contractor shall provide training and ongoing customer support for this access.

a. What is the number of personnel assigned to "the DoD TRICARE Operations Center and all Health Benefits Advisors and Beneficiary Counseling and Assistance Coordinators located in each region?"

RESPONSE: BCACs are listed on the Lead Agents web sites. Offerors may assume an equal number of HBAs located at the same facilities. We will be reprocuring the services of the TRICARE Operations Center using different requirements prior to the start of health care delivery. As such, an exact number is not available; however, for bidding purposed, offerors may assume 20 individuals.

b. The requirement addresses "training and ongoing customer support". Would computer based training / distance learning satisfy this requirement? What is the government expectation of "ongoing support"?

RESPONSE: The contractor may propose any method of training. In doing so, the offeror should explain clearly how their proposed method will achieve trained individuals. Ongoing support means ongoing assistance to personnel accessing the system as problems surface or additional training is needed.

774. C-7.27.1, Page 32 - The contractor shall provide unlimited read-only off-site electronic access to all TRICARE related data maintained by the Contractor. Minimum access shall include two authorizations at each MTF, two authorizations at each Surgeon General's Office, two authorizations at the Regional Director's Office, two authorizations at Health Affairs, two authorizations at TMA-Washington, two authorizations at TMA-Aurora, and authorization for each on-site Government representative. The contractor shall provide training and ongoing customer support for this access.

The requirement addresses "training and ongoing customer support". Would computer based training/distance learning satisfy this requirement? What is the government expectation of "ongoing support"?

RESPONSE: Please see our previous response.

775. C-7.2, Page 26 - Describes an "audit to be performed of referrals from each MTF monthly to validate the return of all required information within the standard addressed in paragraph C-7.1.16." RFP Section C-7.1.16. appears to directly correlate to the performance standard addressed in RFP Section H-8.m.

Is this audit the measurement for the performance standard H-8.m and the correlating requirement in Section C-7.1.16? If so, does that mean that the performance standard applies only to those Specialty Care Referral/Consultation/Operative reports generated as a result of a referral from the MTF?

RESPONSE: No, this audit is performed by the contractor to monitor and report on their own performance, design a corrective action plan if necessary, and to also report the results of this audit to the Government. The Government, at its discretion, will conduct it's own validation audits. However, the Government will use the Monthly Referral Report as outlined in the TOM, Chapter 15, Section 3, paragraph 7.0.

776. C-7.20.2, Page 28. Please provide clarification of what provider information the contractor should provide to the out of jurisdiction beneficiaries.

RESPONSE: As an example, the contractor shall assist traveling beneficiaries who call in locating a network provider, even if the beneficiary lives outside of the contract's jurisdiction, who has an urgent medical need.

776a.C-7.1.1 requires that "the contractor's network shall be accredited by a nationally recognized accrediting organization no later than 18 months after the start of health care delivery in all geographic areas covered by the contract". We understand that the second part of C-7.1.1 clarifies circumstances where the contract and the accrediting body have different standards for the same activity when it requires that "when this contract and the accrediting body both have standards for the same activity, the higher standard shall apply".

If the provider network were credentialed by an NCQA accredited credential verification organization (CVO), would that satisfy this requirement?

RESPONSE: Accredited verification organizations are not the accrediting organization. If you chose to use NCQA, that organization must issue the accreditation.

777. H-8.i and H-5.d, Page 51: Claims processing accuracy shows up in two separate penalty provisions. In the Performance Guarantee (Section H-8.i, Page 50), the absolute value of errors is audited to ensure that the absolute value remains within a 2% band and in Section H-5.d (Page 48) an sample result is extrapolated to the population with no tolerance band. Since sampling theory does not provide for "accuracy assured" point estimation extrapolation to the population, but only for tolerance or confidence intervals, why is there no tolerance band on this Disallowance so that the Disallowance and Performance Guarantee expectations are statistically consistent and conceptually consistent with each other?

Recommendation: Delete the Disallowance provision of Section H-5.d all together or at least both of these sections should contain a tolerance band of 2% and consistent measurement of the penalty/disallowance from the tolerance band, not from zero.

RESPONSE: The Government does not intend to amend the solicitation. We disagree that there are two separate penalty provisions. H-8 addresses performance guarantees based on the Government's required standards. H-5 addresses FAR

52.216-7, Allowable Cost and Payment, which is a required clause for cost-reimbursable contracts. As with all cost-reimbursement contracts, the Government simply cannot reimburse a contractor for any unallowable costs. All cost-reimbursement contracts have clauses that allow the Government to conduct audits to verify if payments made contractors were for allowable costs; and provides the Government the rights to suspend payments, deduct from payments, recover funds, or otherwise protect the Government.

778. L.13.e(5), Page 87 Factor 1 – Technical Approach
Subfactor 5 - Provide ready access to contractor maintained data to support DoD's financial planning, health systems planning, medical resource management, clinical management, clinical research, and contract administration activities.

The offeror shall describe access to and use of its proposed on-line, real-time data storage system. The offeror shall also describe the training and on-going support the offeror will provide the Government and include a specific reference to those access points required by the technical requirements in Section C. The offeror shall describe the content of the data that will be available to the Government, restrictions and/or limitations.

a. What is the government definition of "real time data storage.system."

RESPONSE: The Government wants access to the data as it is updated minute by minute, not access to a storage system that the data could be days or weeks old.

b. The requirement addresses "on-going support". Training and on-going support for what?

RESPONSE: Training and on-going support for those Government individuals who will be accessing the contractor's system. Training, as an example, would involve assigning access passwords, how to navigate through modules and what information is located where. Support could be a help desk call-in type of arrangement.

c. Are access points the same as channels?

RESPONSE: We don't understand the use of channels. As referenced in RFP Section L-13e.(5), access points are those locations identified in Section C that the Government requires access to the data warehouse; e.g., the Surgeons' General offices, the Regional Offices, etc.

779. 22. L-13.f(2)(b) states that "The offeror shall provide a narrative that describes the experience that the prime contractor and first tier subcontractor(s) has in performing work that is relevant to this solicitation. The narrative shall not exceed 25 pages." Section M.7.b. states "The Government will evaluate past performance as it relates to fulfilling the functional requirements of all elements in Section C of this request for proposals (RFP)." (emphasis added). We have questions in this regard:

a. We assume, given the Section L and M statements, that the government desires that the Past Performance Narrative be provided in same general order as requirements are described in Section C. Is this assumption correct?

RESPONSE: While we are not requiring the same order as Section C, that would be helpful. In a future amendment, the first sentence in Section M-7b. will be modified so that offerors do not have to address each and every Section C requirement.

b. Given that Section C of the RFP is 11 pages long and the limitation on Past Performance Narrative is 25 pages, it is difficult to discuss Past Performance on 11 pages of requirements in any meaningful way in 25 pages of narrative. Will the government consider either reducing the number of Section C requirements that need to be discussed or expanding the narrative page limitation so that all Section C requirements can be discussed in a meaningful fashion?

RESPONSE: Please see the response to 779a. Based on the change to Section M, we are confident that 25 pages is sufficient.

c. We are assuming that a Table of Contents should be included to assist the government reviewer and that it does not count against the page count. Is this assumption correct?

RESPONSE: A table of contents is not required for the 25 page narrative but if furnished it will be included in the 25 page limit. However, if your question is concerning providing a table of contents for the whole past performance proposal that table of contents will not be included in the 25 page limit and would be helpful for the reviewers.

780. Section L-15 states "neither the contractor, nor the Government, shall assume any Resource Sharing savings …" for developing the estimate of Option 1 health care costs. Does this mean that, for purposes of estimating Option 1 health care costs, an offeror should assume:

a. All Resource Sharing agreements are cancelled just before Option 1 begins, and any new Resource Sharing agreement (in Option 1) will not produce savings; or

RESPONSE: Existing resource sharing agreements will, in fact, be terminated at the conclusion of the existing contracts. This is because these contractual agreements with current contractors expire with the current contracts. As RFP Amendment 2 states: "Current resource sharing agreements will terminate as of the commencement of health care delivery under the newly awarded contracts. However, offerors should assume that an amount equivalent to current resource sharing expenditures shall be provided to the direct care system. Offerors should further assume that these expenditures will be used the augment direct care capacity (thereby avoiding purchased health care costs) in manners deemed most efficient by MTF/clinic commanders. Offerors should use their judgment as to the impact of these expenditures (i.e., health care savings generated)."

b. Current, past, and future Resource Sharing agreements produce (and have produced) zero savings?

RESPONSE: Please see our previous response

c. Are there different assumption(s) than a or b above?

RESPONSE: Please see our previous response

If the answer is (a) above, then offerors should expect a significant jump in health care costs, from FY 2001 to Option 1, due to the cancellation of Resource Sharing agreements. This is because Resource Sharing agreements are generally believed to be very cost effective, in terms of CHAMPUS costs.

For example, suppose that an offeror believes that Resource Sharing agreements have a savings/cost ratio of 1.75 overall. So, for every $1 spent on Resource Sharing, the offeror saves (and has saved) $1.75 in other CHAMPUS costs. Suppose also that the total Resource Sharing costs in FY 2001 is $100 million for a particular Region. If all Resource Sharing agreements are cancelled just before Option 1, then the offeror should expect an increase of $75 million, due to those cancellations (add the $175 million that had been saved but is no longer avoided; minus the $100 million that is no longer spent on Resource Sharing).

If the answer is (b) above, then there is not a necessary direct adjustment to the Option 1 target health care costs, for any assumed change in Resource Sharing activity. The offerors are forced to assume a savings/cost ratio of 1:1 for all Resource Sharing agreements. Any anticipated changes in the extent of Resource Sharing do not affect the target cost. If an offeror believes that increased Resource Sharing activity actually will reduce target costs, then that offeror could consider that assumption in the development of target costs.

d. Please clarify the assumption of no Resource Sharing savings.

RESPONSE: Please see our previous response

781. Section L-13.f(3)(a) Page 88 - These contracts are filled with penalty and disallowance provisions. In addition, the cash flow terms are significantly worse than previous TRICARE contracts. These two items combine to form significantly more risk than the current contracts. Considering the extremely onerous financial terms of these contracts, could you comment on any specific financial worthiness tests TMA may require prospective awardees to pass?

RESPONSE: The Contracting Officer will make an assessment of a prospective contractor's responsibility, which includes financial resources, in accordance with FAR Subpart 9.1. A conscious effort was made to reduce risk and make cash flow better than in past contracts, so we do not understand the basis for the comment. We also disagree with your statement that this contract is "filled" with penalty and disallowance provisions. The Government, for example, stated many processing standards in the TOM, Chapter 1, Section 3 but has only identified 10 critical performance guarantees that tie dollar guarantees to contractor's achievements.

782. Section L-13.f(4)j, Page 89 - The Case Management/Disease Management CLIN is the only administrative cost component that is Cost Plus. Having this particular component (which incidentally is very small relative to the total administrative cost) will require that each contractor, the DCAA and either TMA or a delegated ACO organization within the government incur literally thousands of hours annually to prepare, audit and negotiate final indirect overhead rates. Have you considered the economics of this provision to the overall cost of this program to the Government?

Recommendation: Consider a Time and Material CLIN as opposed to a Cost Plus Fixed Fee or require the contractor to bid overhead rates that will be acceptable for this CLIN only for the entire life of the contract. This would save the government hundreds of thousands of dollars over all three contracts and all 5 option periods.

RESPONSE: This is a very good point and we do not disagree with your assessment. A time and material type CLIN was considered while preparing this RFP, but a cost-plus-fixed-fee CLIN was decided upon in the end.

QUESTIONS 783-785 REFER TO THE TRICARE SYSTEMS MANUAL

783. 3.4. Public Key Infrastructure
The contractor shall comply with DoD policy for enabling networks, web servers
and client server applications to make use of the security services made available by the DoD PKI. The Common Access Card (CAC) is the DoD wide primary token platform for PKI.

Should contractor's networks, web servers and client server applications comply with the DOD Public Key Infrastructure Roadmap? What are the main PKI compliance policies?

RESPONSE: Please note that the TRICARE Systems Manual, Chapter 1, Section 1.1, Subsection 3.4 has been revised. Please refer to the revised Subsection 3.4 for information regarding PKI requirements.

784. 4.1. DEERS and MHS Systems Telecommunications

4.1.1. The primary communication links shall be via IPSEC virtual private network (VPN) tunnels between the contractor's primary site and the DEERS primary site and between the contractor's primary site and the MHS primary sites. The VPN shall provide additional level of security by encryption of the data transmission within the network.

4.1.2. To ensure VPN interoperability, the contractor shall use the currently approved MHS standard VPN device. The current approved VPN device is the Avaya VSU-5000, 2000, VSU-1010E, or other fully-compatible Avaya VPN appliance to establish Internet Key Exchange (IKE) VPN tunnels with various MHS sites via commercial or Defense Information Systems Agency (e.g. NIPRNET) connectivity. The standard MHS VPN solution may change over time and the Contractor is expected to upgrade/comply accordingly. The Contractor shall support the integration of this VPN appliance as part of the MHS IKE VPN domain. These VPN appliances shall be configured in accordance with specific VSU configuration guidance provided by the MHS, and all VPNs (unless otherwise directed) shall be operated in compliance with FIPS 140.

Does the word primary refer to the main link between the contractor's site, or all links between the contractor and DEERS and MHS primary sites?

RESPONSE: All traffic flowing between the contractor's site(s) and DEERS or DoD Military Medical facilities shall be encrypted using an approved VPN device. As a result, this requirement applies to all communications links that transport data to/from DEERS or medical facilities.

a. Related question: The Contractor shall place the VPN appliance device outside the Contractor's firewalls and shall allow full management access to this device (e.g. in router access control lists) to allow Central VPN Management services provided by the Defense Information Systems Agency (DISA) or other source of service as designated by the MHS to remotely manage, configure, and support this VPN device as part of the MHS VPN domain. Section 4.1.8 states that the contractor will troubleshoot and maintain longhaul lines communications and communications equipment, up to and including CSUs/DSUs.

This seems to be in conflict with Section 4.1.2, which implies that the government will maintain VPN appliances on the contractor's premises.

Will the government expect the contractor to support the VPN appliance device that is outside of its firewall?

RESPONSE: The contractor shall purchase, install, and maintain (e.g. purchase hardware/software maintenance contracts) the VPN appliance. Management of the VPN appliance, including application of VPN software updates, will be provided by DISA or other source designated by the MHS. MHS-provided VPN maintenance includes management of the MHS VPN domain and the application of needed VPN software upgrades to ensure compatibility with the MHS VPN domain.

785. 4.1.6. For connectivity between on-base Contractor locations (e.g. a Contractor LAN on a military installation), the Contractor shall coordinate with the Military installation communications authority (e.g., DISA Base Communications) and the medical facility in the acquisition of secure connectivity from the Contractor's area to the MHS network. TMA is responsible for the implementation of connectivity for on-base or within-the-MTF connectivity to Contractor facilities within the military facility. The Contractor must coordinate his corporate connections directly with the installation but TMA will handle connections to local MTF systems, such as CHCS, if the Contractor facility is within the MTF. If additional communications are required, the Contractor shall coordinate with the medical facility/communications office and procure via the base communications office or DISA.

a. What will be the standard for accessing CHCS if the contractor is within the MTF?

RESPONSE: PLEASE NOTE: The second sentence in 4.1.6., "TMA is responsible for the implementation of connectivity for on-base..." will be changed to read, "The Contractor is responsible for the implementation of connectivity for on-base..." The third sentence in 4.1.6., "The Contractor must coordinate his corporate connections directly with the installation but TMA will handle connections to local MTF systems..." will be changed to read, "The Contractor must coordinate his corporate connections directly with the installation to connect to local MTF systems..."

Access must be negotiated with the CHCS host MTF by the contractor on a facility by facility basis. The contractor is required to meet the security requirements of the CHCS host MTF Designated Approving Authority for both physical network connectivity as well as user accounts on CHCS.

b. Will there be one standard for connecting to CHCS for all services?

RESPONSE: While there are standards-based LANs deployed within the MHS, there may be variances in the physical connectivity as well as the local process for requesting and implementing connectivity and access to CHCS. As a result, there is not a single standard for connecting to CHCS for all sites or services.

c. Will the contractor be required to purchase data lines and communication equipment via the base communications office?

RESPONSE: Please see the answer above. The contractor is required to provide connectivity from their location(s) to DoD medical facilities, and yes, there may be cases wherein the contractor will be required to acquire communications data lines and/or equipment via the base communications office (as opposed to direct acquisition by the contractor). This will be site-specific and must be determined by contractor coordination with DISA as well as the responsible base communications office for each facility.

The answer to this question is also dependent on whether the connectivity is purely on-base (e.g. between a contractor's on-base facility to the medical facility) or between an off-base contractor's facility to a remote medical facility. In the case of on-base connectivity, the contractor must coordinate with the responsible communications office authority to determine the method of connectivity and the specific contractor's responsibilities for acquiring data lines and/or equipment. For off-base connectivity, the contractor must coordinate with DISA for the long-haul communications component as well as the base communications office as required to extend the connectivity to the medical facility. The contractor's are also responsible for compliance with DoD, Military Service, and local communications security as well as Port, Protocol, and Service requirements.

QUESTIONS 786-789 REFER TO THE TRICARE OPERATIONS MANUAL

786. TRICARE Operations Manual, Chapter 12, Section 3, Page 1. Is beneficiary phone access required at the TSCs?

RESPONSE: Keeping in mind Objective 2 of the contract, offerors should review the TOM, Chapter 12, Section 3, paragraph 2.0; and the RFP Section 7.16 to determine if phone access is necessary for maintaining beneficiary satisfaction at the highest level.

787. TRICARE Operations Manual, Chapter 12, Section, Paragraph 3.0, Page 1. How will the calls be identified for routing from the 1-800-TRICARE number to the contractor number?

RESPONSE: The final design of the new TRICARE Information Center operations has not been finalized, but it may be an automated system keyed to the caller’s area code or an individual may answer and then route. These two possibilities are only examples and are not to be taken to be the only possibilities.

788. TRICARE Operations Manual, Chapter 12, Section 5, Paragraph 3.0, Page 1. Will the calls to 1-800-TRICARE be greeting through an IVR prior to being routed to the contractor number?

RESPONSE: See the response to Question 787.

789. TRICARE Operations Manual, Chapter 1, Section 3, Paragraph 3.4, Page 7. Will the contractor performance measurements begin when the call enters the contractor's ACD switch? Please explain.

RESPONSE: The telephone performance measurements begin when the call enters the contractors telephone system.

790. Section B identifies Item No. 0105 as Case Management/Disease Management as a Cost plus fixed fee line item, Item No. 0105AA estimates the cost to be $2,000,000 per option period and Item 0105AB identifies it as a Fixed Fee.

a. Does the Government intend that the Contractor NOT spend more than $2,000,000 per option period on Case Management/Disease Management?

RESPONSE: No. As a cost-reimbursable item, the Government will reimburse all allowable costs associated with approved cases, even if the costs exceed $2,000,000. The $2,000,000 is an estimate at this time.

b. If the Government intends that some new services will be funded in addition to those included in medical management programs which typically include Disease Management and Case Management, could you provide more specificity on the services which are being segregated out from or added to medical management programs? As stated, this requirement may permit less funding for these activities than are now being provided under existing MSC contracts and result in a contraction of services. MCS contractors may be spending more than $2,000,000 per option period on these activities.

RESPONSE: The $2,000,000 is only an estimate at this time and one should not construe the estimate to the level of services. If the cost exceeds this estimate as the question suggests, the Government will obligate additional funding for the approved cases. The Government has assumed the cost risk, so contractors will have no incentive to do anything that would result in a "contraction of services".

791. C-7.7.1 requires that "the contractor shall operate programs designed to manage the health care of individuals with high cost conditions or with specific diseases for which proven management programs exist." Case management programs "manage the health care of individuals with high cost conditions". Disease management programs are based on "specific diseases for which proven management programs exist".

Are the activities described in C-7.7.1 limited by the $2,000,000 per option period limit outlined in Section B?

RESPONSE: No. There is not a cost limit. See 790.

792. The definition for "Demand Management" was not included in the most recent version of the T-Nex Manuals. Please provide a current definition of "Demand Management."

RESPONSE: There is no formal TRICARE definition. Demand Management is a broad term, but in general means giving people information that helps them use medical care appropriately. Some experts say the goal of demand management is not to reduce the demand for services or to restrict access to care, but it is to

provide resources to help people make better decisions about self-care. One example would be helping consumers decide whether to seek medical attention for illnesses or injuries or to treat themselves. Other examples may be found in the literature.

793. Section H.8.b, page, Performance Guarantee, last sentence in section b., Page 49 states "For the purposes of this provision, the term "performance standard" is defined as the contract standards that are restated in this provision." Also reference RFP Section M.6 on page 93 which states, "Where the Government has not specified a minimum standard, the Government will consider offers that commit to higher performance standared(s), if the offeror clearly describes the added benefit to the Government."

a. If an offeror proposes a higher performance standard for a requirement specified in Section H.8 and the offeror can show the added benefit to the Government by the proposing the higher performance standard, will the offeror's technical proposal be scored higher than it would be score if the offeror proposed to meet the RFP minimum performance standard?

RESPONSE: The evaluators will review any proposed "enhancement" to the performance standards listed in both RFP Section H.8 and the TOM, Chapter 1, Section 3 and make an independent judgement as to the value of the proposed higher performance standard. There is a potential for an offering of a higher performance standard to have a positive effect on the "scoring."

b. If an offeror proposes a higher performance standard for a requirement specified in Section H.8 and the offeror can show the added benefit to the Government by the proposing the higher performance standard, and the offeror is awarded the contract, will the contractor then be held to the higher performance standard for meeting the performance guarantees?

RESPONSE: Yes, definitely. The proposed higher performance standard will be incorporated into the award document.

794. Section L.13.f. Written Proposal Submission, page 87, states "The offeror may, however, propose standards that exceed the Government's minimum."

a. Are the standards addressed in the quoted RFP section above performance standards under the performance guarantee in RFP Section H-8 or Section C-2 or both?

RESPONSE *REVISED 30 December 2002.*

RESPONSE: Where the Government has specified performance standards, the offeror need not repeat them. However, where the offeror must state where it proposes to exceed the Government performance standards (See Amendment 0004). Then offerors must propose standards where the Government has a requirement but has not mandated a minimum standard. For example, the Government has stated that any new enrollment application received by the 20th day of the month, the effective date shall be the first of the next month. However the Government has not set a timeliness standard for how soon an enrollment must be processed.

b. If an offeror proposed standards higher then the Government minimum, will the offeror receive additional credit?

RESPONSE: Please refer to the answer to Question 793.

795. Reference question/answer #36 and RFP Section C-7.20.2 page 28
RFP Amendment 0001 removes all references to urgent care situations. The answer to question 36 has re-introduced the term "urgent situation". Please clarify if "urgent situations" are to be considered in any way regarding this 24/7 phone line service.

RESPONSE *REVISED 30 December 2002.*

RESPONSE: Please refer to the answer to Question 776.

796. Reference question/answer #37 and RFP Section C-7.33, page 32
The intent of this question was to seek guidance regarding the RFP Requirement to implement the "President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry's Consumer Bill of Rights and Responsibilities." Is the Government requiring the Contractor to implement a process to meet a law that has not yet passed? Please clarify this requirement.

RESPONSE: Yes, by Presidential Executive Order, Government agencies must comply with the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry's Consumer Bill of Rights and Responsibilities" recommendations. The Government is requiring the contractor, as an agent of the government, to follow the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry's Consumer Bill of Rights and Responsibilities" determinations.

797. Reference question/answer 40 and RFP Section H-8.i. page 51

This question asked the Government about the MTF's ability to meet performance standards when the Contractor made a specialty referral. The Governments response did not answer the question. Please explain the Governments position when a potential situation occurs when the MTF accepts the Contractors specialty referral, but then finds it is unable to meet the specialty referral standards. For example, the Specialty Care Referral/Consultation/Operative Reports standard.

RESPONSE: In the phrase, "but then finds it is unable to meet" we assume that you mean that the MTF can not meet the 10 working days standard for returning a consultation or referral report. Section H-8m measures the timeliness of network specialty providers not the MTF. The contract does not set standards for the MTFs.

798. Reference question/answer #52 and RFP Section M.6.c.page 94
This question deals with the Requirement for the Contractor to meet the 50th percentile of the NCQA's HEDIS measurements. The requested clarification deals with the understanding of the MTFs ability to participate and also meet these same HEDIS measurements. As stated in the RFP document and re-inforced at the Pre-Proposal conference, the TRICARE program represents an integrated healthcare delivery system, and requires the cooperation and coordination of both the Government and Contractor. To suggest in the response to this question that "The internal operation

of the MTFs are not the concern of this contract", is very concerning. We again request a clarification to our question as follows:

a. Will the MTF be held responsible to the same HEDIS requirements as the contractor?

RESPONSE: In a future amendment, the requirement for the contractor to meet the HEDIS standards will be removed.

b. If the MTFs are not held responsible to the some HEDIS requirements, please explain how the Government and Contractor will ensure a "fully integrated patient information system" and the ability to meet the HEDIS measurements.

RESPONSE: In a future amendment, the requirement for the contractor to meet the HEDIS standards will be removed.

799. Reference question/answer #53 and RFP Section M.4.a. page 92
This question asked for clarification and elaboration on the RFP topic, "Proposal Risk" The answer does not elaborate or provide the information we were seeking. Please provide information regarding Proposal Risk as it relates to:

a. How will the Government judge the offerors technical proposed approach to determine a Proposal Risk?

RESPONSE: It will be a subjective judgement by the evaluators as to how much risk is associated with an offeror's approach to meeting one of the subfactors

b. Will the offeror's Past Performance volume be evaluated for Proposal Risk as it relates to this Technical approach evaluation?

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RESPONSE: No. The past performance risk assessment by the evaluators represents the evaluation of an offeror's past work record, to assess the Government's confidence in the offeror's probability of successfully performing the requirements of the contract.

c. Will each Subfactor be evaluated for Proposal Risk?

RESPONSE: Yes.

d. Section L-13. e. Oral Presentation Topics, does not contain a reference to "Proposal Risk". Does the Government have a specific format or desired set of data that should be addressed during the Oral Presentation that deals with Proposal Risk?

RESPONSE: No.

800. Reference question/answer #78
This question was submitted regarding how the Government will evaluate Performance Standards. The response incorporated the phrase, "…the offeror's ability to deliver the contract objectives and the proposal risk associated with the offer". Please explain how the Government will assess the offeror's proposal risk.

a. Will the offeror's Technical approach be evaluated for potential risk?

RESPONSE: Please refer to the response to Question 799.

b. If so how will the Government make these judgements?

RESPONSE: Please refer to the response to Question 799.

c. What materials or explanations are necessary to prove the offerors's Technical approach is sound?

RESPONSE: That decision is left to the discretion of the offerors.

d. Will the offeror's Past Performance be evaluated to assess proposal risk?

RESPONSE: Please refer to the response to Question 799.